THEDE MOHR HIGHHOUSE V. UNITED STATES OF AMERICA
CIVIL ACTION NO: 1:14-CV-00140-JMH

Exhibit L

February 18, 2015
Richard Paul Bonfiglio, M.D.
Physical Medicine and Rehabilitation Evaluation

RICHARD PAUL BONFIGLIO, M.D.
Physical Medicine and Rehabilitation

PHYSICAL MEDICINE AND REHABILITATION EVALUATION

HIGHHOUSE, THEDE MOHR

#50-84-69

FEBRUARY 18, 2015

REFERRED BY:

Ms. Christina Nacopoulos

349 West Sixth Street, Suite 1

Erie, Pennsylvania 16507

REASON FOR REFERRAL:

Medical evaluation regarding current medical condition, future care needs, and prognosis.

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PHYSICAL MEDICINE AND REHABILITATION EVALUATION

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RECORDS REVIEWED:

Medical records from Erie VA Medical Center

Medical records from Saint Vincent Health Center

Medical records from Emergycare

Medical records from VA Medical Center, Jacksonville, Florida

Medical records from Miami VA Medical Center

Medical records from UPMC Northshore Neurology

Medical records from UPMC Hamot

Medical records from Great Lakes Neurosurgery & Neurointervention

Medical records from Associates in Nephrology, Sam Wu, M.D.

Medical records from Bureau of Disability Determination Social Security Office

Deposition transcript of Charles E. Romero, M.D., Treating Neurointerventionist taken May 22, 2015

PHYSICAL MEDICINE AND REHABILITATION EVALUATION

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FEBRUARY 18, 2015

EVALUATION LOCATION:

Patient's home

9091

Northeast, Pennsylvania

CLINICAL HISTORY:

Mr. Thede Mohr Highhouse is a 59-year-old right handed white male who was born on August 23, 1955. He was seen in the Emergency Department of the Erie Veterans Administration Medical Center on January 22, 2011. He presented with left hand pain after falling while skiing. He also reported hitting his bead, but denied any loss of consciousness or cephalgia. Left wrist x-rays found a slightly impacted, severely dorsally angulated distal radial metaphysis fracture without definitive extension into the articular surface. The fracture was reduced and a sugar tong splint was applied. An unenhanced head CT scan detected an apparent focal enlargement of the top of the basilar artery that was worrisome for a basilar tip aneurysm. The radiologist recommended a brain MRA for further characterization. An MRI and MRA on February 4, 2011 ordered by Lydia Maring, CRNP, showed an unremarkable appearance of his brain, but revealed a rather large basilar tip aneurysm and a possible anterior communicating artery aneurysm. The results were reported on February 4, 2011 and verified on February 10, 2011.

On March 17, 2011, Mr. Highhouse was seen in the Emergency Department of the Erie Veterans

Administration Medical Center. He presented with abdominal pain, heartburn, and midback pain with radiation to his abdomen. He denied having associated nausea. A CT scan of his abdomen and pelvis revealed a nonobstructive 6 millimeter renal calculus within the lower pole of his left kidney with an adjacent nonobstructing 2 millimeter renal calculus within the lower pole of his left kidney, and a nonobstructing 2 millimeter renal calculus within the interpolar region of his right kidney. No urethral calculus or hydronephrosis was identified. The scan also found non-specific, gastrohepatic and peripancreatic adenopathy and scattered diverticulosis. An ultrasound of his gallbladder detected gall stones and minor gallbladder dilatation. Left wrist x-rays found a healing fracture. He was discharged to home with a diagnosis of right upper quadrant pain due to mild cholecystitis. Discharge medications included Vicodin, Motrin, and Zantac.

On March 18, 2011, Mr. Highhouse was seen in consultation by James T. Salmon, M.D., for a surgical consultation regarding his abdominal and back pain. Dr. Salmon discussed laparoscopic and open approaches for cholecystectomy with Mr. Highhouse.

On March 24, 2011, Mr. Highhouse was seen at the VA by Lydia Maring, CRNP with left jaw pain attributed to a tooth ache. Treatment included Ibuprofen and Clindamycin. No mention was made of his basilar tip and anterior communication artery aneurysms; no referral, consultation, or opinion from neurosurgery, neurology, or neurointervention was obtained by the VA, nor was Mr. Highhouse ever afforded timely treatment for his basilar tip aneurysm.

On October 20, 2011, Mr. Highhouse was again seen at the VA due to recurrent left lower jaw pain. He was found to have a dental infection and was again treated with Clindamycin.

A VA progress note from January 24, 2012 recorded that Mr. Highhouse was having severe epigastric pain rated by the patient as 8 out of 10. His blood pressure was elevated to 209/103 and he had sinus bradycardia with 59 beats per minute. A CT scan of his abdomen and pelvis found small nonobstructing bilateral renal calculi that were stable from the previous examination. He had multiple mildly enlarged upper abdominal lymph nodes that were stable from the previous examination; there was slight thickening of the wall of the gallbladder which may have

been due to gallbladder contraction. Mild focal adenomyomatosis could not be excluded. There was a small left adrenal adenoma. Sigmoid diverticulosis was present, but without evidence of diverticulitis.

A head CT scan revealed no evidence of an acute intracranial abnormality. However there were findings highly worrisome for an aneurysm of the tip of the basilar artery. An MR angiogram of the brain was recommended if not already performed. The findings were reportedly conveyed to Dr. Lindemuth at 1900 hours. A CT scan of his sinuses showed minimal chronic right maxillary and right ethmoid sinusitis with no evidence of acute sinusitis. There was moderate nasal septal deviation to the right. An EKG showed sinus bradycardia with sinus arrhythmia. Based on the comparison of the CT imaging from January 22, 2011 and January 24, 2012, Mr. Highhouse's basilar tip aneurysm grew significantly in size and shape from 7.7 by 8.0 by 8.0 millimeters to 11.5 by 12.9 by 12 millimeters.

On January 30, 2012, Mr. Highhouse was seen in an EmergyCare facility. He reported feeling

weak and having a headache that was worse when he tilted his head upwards. He had vomited once on standing. Examination found that he was alert and oriented and that he did not have facial drooping or recognized weakness or dysarthria. Mr. Highhouse was transported by ambulance to the Erie VA Hospital Emergency Department. He continued to report a headache, nausea, and neck pain. He also had photosensitivity, but no blurred vision. No neurological deficit was found and he did not have a fever, chills, or a rash.

An EKG found sinus bradycardia that was unchanged from a prior EKG. A chest x-ray revealed no acute process. A CT scan of his head detected an acute subarachnoid hemorrhage, likely related to the 8 millimeter aneurysm of the basilar tip found on the prior studies. The results were reported to Dr. Gobble.

Mr. Highhouse was transported to Saint Vincent Health Center due to the subarachnoid hemorrhage. There he reported a severe headache and nausea that was treated with Morphine and Zofran. On January 30, 2012, Mr. Highhouse was admitted to the Intensive Care Unit of the

Saint Vincent Health Center due to a ruptured basilar artery tip aneurysm. Initial management included albumin and Nimodipine. On January 30, 2012, Dr. Romero did a cerebral angiogram and coil embolization of the ruptured basilar tip aneurysm, during which the aneurysm was measured to be 13 by 12 by 11 millimeters on the 3D reconstructive images. The aneurysm was treated with three detachable coils.

Brian E. Dalton, M.D., a neurosurgeon, saw Mr. Highhouse in consultation on January 31, 2012. Mr. Highhouse was still reporting headaches, but they were less intense. He continued to have photophobia. Dr. Dalton diagnosed subarachnoid hemorrhage secondary to ruptured basilar tip artery aneurysm with patient status post coiling of the aneurysm. He reported that he planned to follow Mr. Highhouse closely in case neurosurgical intervention was warranted.

On January 31, 2012, a head CT scan showed interval placement of coils and a basilar tip aneurysm and minor subarachnoid bleeding in the left posterior parietal region. A transcranial doppler study on February 2, 2012 was normal with no evidence of vasospasm or a shunting

pattern. On February 3, 2012, a transcranial doppler was normal with no evidence of vasospasm, shunting, or focal narrowing.

On February 4, 2012, Sam Wu, M.D. saw Mr. Highhouse in consultation regarding his hyponatremia. Dr. Wu suspected an element of cerebral salt-wasting syndrome likely related to his cerebral aneurysm coiling and subarachnoid hemorrhage. He deferred to neurology for management of Mr. Highhouse's blood pressure. A brain CT scan found no midline shift, mass effect, or intracranial hemorrhage. There was no new calvarial defect. Some mild mucosal thickening in the ethmoidal sinuses, especially on the right, compatible with sinusitis was seen. His mastoids were unremarkable. The test was similar intra-cranially compared to the prior study of February 2, 2010.

William Mecca, M.D., a cardiologist, saw Mr. Highhouse in consultation on February 5, 2012 regarding his atrial fibrillation and flutter. The patient denied associated palpitations or other symptoms. Dr. Meccas recommended an Amiodarone drip and Lopressor. Thyroid function

testing was also recommended, but he believed the arrhythmia was most likely due to the aneurysm and the "physical stress of having the aneurysm worked on."

An occupational therapy assessment on February 6, 2012 found that Mr. Highhouse was independent with basic activities of daily living. An echocardiogram on February 6, 2012 was normal including normal left ventricular function with an ejection fraction of 55 to 60%.

On February 7, 2012, Mr. Highhouse was seen in consultation by Floyd Csir, M.D., urologist, due to his difficulty voiding. A Foley catheter found 1,000 cc's of residual urine. Flomax and Proscar were prescribed and the Foley was left in place. A physician progress note recorded that Mr. Highhouse was alert and oriented and could ambulate independently. He was further described as having impaired short term memory and being inappropriate at times. His speech was clear and he moved all four limbs with no drifts or droops detected. His back pain and headache were better with medication.

A transcranial doppler on February 8, 2012 was a normal study, although the Lindegaard ratio was mildly elevated. There was no evidence of true marked elevations suspicious for vasospasm. A progress note recorded that Mr. Highhouse was alert and oriented times three, but inappropriate at times. His speech was clear and he followed commands. He moved all limbs equally and was strong; he denied numbness or tingling. His gait was steady and his Foley catheter was intact. Laboratory testing on February 9, 2012 found leukocytosis, hyponatremia, and hypoglycemia.

On February 9, 2012, Mr. Highhouse was discharged from the hospital. His discharge diagnoses included ruptured basilar tip aneurysm, status post coil embolization, acute urinary retention, new onset atrial fibrillation, and cerebral salt wasting syndrome. His discharge medications included Butabital one to two tablets every 8 hours as needed for severe headache pain, Nimodipine, 60 milligram every four hours for vasospasm, Hydromorphone, 8 milligrams, every 6 hours as needed for severe pain, Flomax, 0.4 milligrams daily, Proscar, 5 milligrams daily, Aspirin, 162 milligrams daily, Sodium chloride 1 gram three times per day for sodium loss, Metoprolol tartrate

12.5 milligrams every 6 hours for elevated blood pressure, and Diltiazem 5 milligrams twice per day as needed for severe muscle spasm.

A VA progress note on February 16, 2012 recorded that Mr. Highhouse was still having short term memory difficulties and reduced attention. He was reportedly having trouble remembering to take his medications. He also reported headaches, blurred vision, and loss of concentration. The memory difficulties were attributed to his having suffered a subarachnoid hemorrhage. His family was assisting him around the clock. An electronic (PDA) reminder for his medications and appointments was discussed. Due to a hearing loss, he was referred to audiology. He was also to be seen by urology regarding voiding difficulties. Ms. Lydia J. Maring, CNP reported that she talked with Mr. Highhouse and his nephew about ordering the brain MRI of February 4, 2011, but not seeing the results that demonstrated an aneurysm. She reportedly apologized for his ruptured aneurysm and admitted that Mr. Highhouse was not informed of the results. Floyd Csir, M.D., urologist, saw Mr. Highhouse in consultation regarding urinary retention. His Foley catheter was removed. Mr. Highhouse returned to the V.A. Emergency Department later that day

due to inability to urinate. A Foley catheter was replaced.

On February 16, 2012 a meeting was held with Mr. Highhouse and his nephew, Dana Lewis and Anthony Behm and Deb Deniziak regarding his brain CT scan from January 2011 and his brain MRI from February 2011 that showed a basilar artery aneurysm. The disclosure admitted that no action was taken and based on the results, he had a subarachnoid hemorrhage. Mr. Highhouse was reportedly informed of his right for a Tort claim. Mr. Highhouse was seen again by urology on February 17, 2102 and his Foley catheter was adjusted and he was prescribed Bactrim.

Mr. Highhouse was seen in EmergyCare on February 23, 2012; he presented with a headache. Per the transport, he state that he had a headache since his aneurysm surgery and his headache had gotten worse that day. He was transported to Saint Vincent Health Center where he was seen in the Emergency Department. A head CT scan showed a recent coiling of an aneurysm. There was no hemorrhage, infarct, mass effect, edema, extra-axial collection, or hydrocephalus seen. He was discharged to home after being treated with Norco for pain and advised to follow-up with

his primary care physician.

On February 27, 2012, Dr. Romero saw Mr. Highhouse for an office visit. He was noted to have a small aneurysm at the anterior communicating artery complex level. An elective coil embolization of the anterior communicating artery aneurysm was to be considered at a follow-up visit in three months.

On February 28, 2012, Mr. Highhouse was seen in the VA Urology Clinic. He was having difficulty voiding and a catheter had to be placed. He was instructed on an intermittent catheterization program. Mr. Highhouse was seen in the Erie VA Medical Center Emergency Department on March 1, 2012. He presented with a constant, throbbing headache, depression, and inability to void. He also reported memory difficulty. He was found to have a urinary tract infection and Bactrim, Flomax, and Proscar were prescribed. On March 2, 2012, Mr. Highhouse was seen by in follow-up by Jaydutt B. Patel, M.D., cardiologist regarding atrial fibrillation. He was found to have a normal weight with a BMI of 24. Dr. Patel noted that he had a single

episode of atrial fibrillation that was attributed to a catecholeminergic surge. Dr. Patel recommended continued aspirin and Metoprolol daily. He was also seen in the VA Urology Clinic; continued intermittent catheterizations were recommended. He was also to continue taking Proscar and Flomax. He was also seen in the Neurology Clinic regarding his headaches. It was noted that he had been released to driving by a neurosurgeon. Ms. Lucy Laporte, audiologist, did an audiology examination on March 7, 2012. His otoscopic examination was normal bilaterally. He had normal hearing from 250 Hertz to 2,000 Hertz bilaterally, but hearing decreasing to a moderately severe sensorineural hearing loss from 3,000-8,000 Hertz in his ears bilaterally. His hearing loss was consistent with a longstanding high frequency hearing loss. He was not believed to be a candidate at that time for hearing aids.

A speech pathology consultation was done on March 7, 2012. Mr. Highhouse reported confusion, memory loss, and decreased attention since his subarachnoid hemorrhage. Since the subarachnoid hemorrhage, he also had slurred speech, inability to form sentences, and worsening memory. Mr. Highhouse scored 84% on the Ross Information Processing Assessment (RIPA)

indicating mild to moderate impairment; only the immediate portion of the RIPA was given. An abdominal ultrasound on March 12, 2012 demonstrated cholelithiasis.

A Behavioral Health intake evaluation was done on March 16, 2012. His chief concern was depression following his brain aneurysm due to his need to relearn how to do everything. He also had an anxiety with panic attacks and increased muscle tension, irritability, anhedonia, isolating behaviors, feelings of worthlessness, and disordered eating with a recent 20 pound weight loss. Mr. Highhouse was diagnosed with Major Depressive Episode and Anxiety Disorder to be managed medically and with individual and group therapy.

On March 20, 2012, Mr. Highhouse was seen by Sam Wu, M.D., nephrologist regarding his history of hyponatremia. Dr. Wu noted that his hyponatremia had resolved and the salt tablets had been discontinued. His blood pressure, kidney function, and electrolytes were unremarkable. Dr. Wu recommended that Mr. Highhouse follow-up with his primary care physician at the VA and noted that Mr. Highhouse was "still a little slow mentally, and having a difficult time

remembering."

On March 22, 2012, Mr. Highhouse was seen by Dr. Meyer, psychiatrist for depression, anxiety, and insomnia. His assessment included:

Axis I: Mood disorder, anxiety disorder, cognitive disorder

Axis II: Deferred

Axis III: Subarachnoid hemorrhage

Axis IV: Unemployed, financial strain

Axis V: Global assessment of function: 65

Dr. Meyer's mental status examination revealed mild cognitive impairment including impaired short-term memory.

On March 30, 2012, Mr. Highhouse's general care was transferred to Dr. Sheryl Russ who noted

that Mr. Highhouse was being treated by speech therapy and behavioral health. On March 30, 2012, Charles Romero, M.D. noted that Mr. Highhouse was to take Plavix. A coil embolization was scheduled for April 17, 2012. He was seen by urology for a follow-up clinic visit. His urinary retention was resolved and Proscar was being discontinued. He was to continue taking Flomax. On April 2, 2012, Mr. Highhouse was again seen at the VA for an office visit. He was still taking Plavix and was scheduled for a coil embolization in Saint Vincent Health Center. On April 5, 2012, Mr. Highhouse was seen by a speech pathologist for training on his PDA and had a group behavioral therapy session.

Mr. Highhouse was admitted to Saint Vincent Health Center on April 17, 2012 due to the anterior communicating artery aneurysm. Dr. Romero performed a stent-assisted coil embolization of the intracranial aneurysm. On April 19, 2012, Mr. Highhouse was discharged to home. The surgical management and hospital admission for the anterior communicating artery aneurysm was directly due to the rupture of the basilar tip aneurysm. On April 24, 2012, Mr. Highhouse was seen by a speech therapist for an unscheduled visit; he reported worsening memory. Additional training

was provided for his PDA. On May 4, 2012, the VA refilled his Dilaudid and Hydromorphone for treatment of his headaches resulting from his subarachnoid hemorrhage.

On May 9, 2012, Mr. Highhouse was seen by Dr. Romero for an office visit. Dr. Romero recommended continued Plavix and cerebral angiography in one year if there was no suspicion for aneurysmal growth or recanalization. On May 24, 2012, Andrew Mecca, M.D. reviewed a 24-hour Holter monitor. The predominant rhythm was sinus, but he also had asymptomatic bradycardia and very rare isolated ventricular ectopy. There was no evidence of atrial fibrillation or flutter.

An office visit with Dr. Romero on July 9, 2012 recorded that Mr. Highhouse should have repeat cerebral angiography in six months to re-evaluate his anterior and posterior cerebral circulation. In ten days, Mr. Highhouse was to discontinue taking Plavix and start taking aspirin 325 milligrams daily. A VA progress note on August 20, 2012 recorded that Mr. Highhouse was overweight with a BMI of 26.

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Dr. Romero saw Mr. Highhouse for an office visit on August 29, 2012. Mr. Highhouse reported that his headaches had worsened. The headache pain was generally unilateral on the right with a throbbing nature. The headaches were preceded by nausea and occasional vomiting. He also had associated left lower quadrant visual obscuration and a kaleidoscope or prism pattern visual disturbance. He also had associated photophobia and phonophobia. The headaches were occurring two to three times per week. There was associated lightheadedness and dizziness at times. His medications included Metoprolol, Aspirin, Flomax, and Fioricet for severe, disabling headaches. Dr. Romero reported that Mr. Highhouse's symptoms were consistent with migraines. Dr. Romero prescribed Amitriptyline for insomnia and headaches and a brain MR angiographic study.

On September 9, 2012, Mr. Highhouse underwent an MR angiogram of his head. The test showed that he had two coiled aneurysms in the anterior communicating artery and the basilar tip. There was some irregularity of the basilar tip and along the left lateral margin there was slight outpouching which could have been residual aneurysmal lumen. There was no abnormality

identified around the anterior communicating artery and no stenosis or vascular malformation. Dr. Romero saw Mr. Highhouse in follow-up on October 1, 2012 and recommended repeat angiography in six months.

On January 30, 2013, Mr. Highhouse had skull x-rays done at the Miami, Florida VA. On February 26, 2013, Mr. Highhouse was seen at the VA where he reported daily frontal headaches with a kaleidoscope effect. He also saw Dr. Russ who noted that he continued to have daily headaches and other symptoms of a traumatic brain injury. A TBI consult was placed. He also saw Dr. Pat McKinstry for a mental health evaluation due to worsened depression over the last year, night sweats, nightmares, and difficulty recalling specifics.

On March 5, 2013, Dr. Romero saw Mr. Highhouse who was reporting worsening frontal headaches over the previous month. The headaches were further characterized as being the abrupt onset of severe pain with several attacks per day with each episode lasting several minutes and then completely remitting. Dr. Romero prescribed Verapamil SR 180 milligrams per day and

supplemental Oxygen for frequent attacks. Celexa was also prescribed with an initial dosage of 20 milligrams that was to increase to a target doseage of 40 milligrams after two weeks. Dr. Romero also scheduled brain MR angiography. On March 9, 2013, Mr. Highhouse was seen by Dr. Pat McKinstry, mental health service, at the Erie VA. Mr. Highhouse reported being eager to begin taking Citalopram (Celexa).

On March 11, 2013, Mr. Highhouse was seen in consultation by Dr. Michael Orinick, III, a physician specializing in Physical Medicine and Rehabilitation. Dr. Orinick documented that Mr. Highhouse had a history a brain aneurysm in 2000 that was detected on an MRI. He had a subarachnoid bleed from the aneurysm on January 29, 2012 manifest by inability to stand with nausea and vomiting. Treatment included coiling of the aneurysm by Dr. Romero.

Mr. Highhouse gave a history of passing out about a week before. He was seen by Dr. Romero that day and reported the syncopal episode; similar episodes had occurred previously associated with his headaches. A repeat brain MRI was planned. Mr. Highhouse further characterized his

headaches as being "cluster headaches" with an associated "kaleidoscope" effect with his vision at times. The headaches and neck pain occurred since his aneurysmal bleed. Periodic severe stabbing pain in his limbs occurred for a couple of minutes at a time; buckling of his legs would occur, but he denied any resultant falls. Mr. Highhouse also described a sleep disorder with awakening every two hours and typically not sleeping for more than four hours per night since the aneurysmal bleed.

Dr. Orinick's evaluation found that Mr. Highhouse could maintain general conversation, but was forgetful at times. Bilateral positive Hoffman and left palmomental signs were noted. He displayed intact finger-to-nose testing, but had mildly decreased heel-to-toe testing.

Dr. Orinick's diagnoses included that Mr. Highhouse was status post aneurysmal bleeding with a subarachnoid hemorrhage and subsequent coiling procedure with residual neurological problems. Mr. Highhouse was also found to have neck pain, headaches, a recent syncopal episode with an associated fall, periodic stabbing pain in his limbs, and chronic lower back pain. Dr. Orinick

referred Mr. Highhouse to Audiology due to his hearing complaints and optometry for his visual symptoms including his "kaleidoscope" vision. Mr. Highhouse was also referred for speech therapy and neuropsychological testing was being considered regarding postconcussive residuals including memory problems and other cognitive issues. Mr. Highhouse was advised to always use a cane with ambulation to prevent falls.

Mr. Highhouse's medical condition was summarized by Dr. Orinick as including neurological residuals from a prior aneurysmal bleed into his brain with a subsequent coiling procedure and a history of a syncopal episode the previous week. The syncopal episode occurred when Mr. Highhouse was bent forward stoking a fireplace in his home. He stood up and had a very severe headache and then lost consciousness for an indeterminate amount of time. Similar episodes had occurred previously and were associated with his headaches. He also had a history of drenching night sweats over the previous couple of months. Examination found upper limb hyperreflexia with bilateral positive Hoffman signs. Cervical spine x-rays and an MRI were recommended to rule out cervical spinal cord compression,

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On March 11, 2013, Mr. Highhouse was seen for an office visit with Sheryl Russ, D.O. for a VA ACCESS appointment. He was found to have a cerebral aneurysm, headaches, depressive disorder, insomnia, chronic hepatitis C, and autonomic neuropathy. His symptoms included night sweats. Dr. Russ increased his Verapamil dosage. Cervical spine x-rays found mild grade I retrolisthesis of C 4 on C 5 without evidence of instability, moderate degenerative disc disease from C 4 to C 7, severe right sided osseous neural foraminal narrowing at C 3 C 4, C 4-C 5, and C 5-C 6. Mr. Highhouse also complained of intermittent bilateral numbness of all of his fingers.

Heidi Mayer, O.D., optometrist, evaluated Mr. Highhouse with an office visit on March 13, 2013. Dr. Mayer found that he had bilateral refractive error presbyopia, bilateral cataracts, and ocular migraines. A brain MR angiogram and MRI on March 19, 2013 found no infarct, hemorrhage, mass lesion, or hydrocephalus, but he was found to have re-canalization of the basilar tip aneurysm with irregular flow signal change at the basilar tip; this was significant change from the previous examination on September 9, 2012. The anterior circulation aneurysm had not re-canalized. A cervical spine MRI showed degenerative cervical spondylosis with moderate

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foraminal changes at C 3-C 4, C 5-C 6 and C 6-C 7. There was normal appearance of the spinal cord.

On March 23, 2013, Mr. Highhouse saw mental health counselor Dr. McKinstrey in follow-up regarding his mental health issues. Mr. Highhouse was reportedly in good spirits, but was unsteady and walked with a cane. He had recent dizziness and was concerned about his medication regimen. His neurologist had recommended the cane due to his unsteadiness.

Charles Romero, M.D. saw Mr. Highhouse on April 2, 2013 for an office visit. He noted that the patient had suffered ruptured cerebral aneurysms. He had not returned to work as a volunteer fireman. He noted that the basilar tip aneurysm had re-canalized. He recorded that Mr. Highhouse's headaches may have been due to increased pressure within the aneurysm. Dr. Romero recommended repeat coil embolization.

On April 4, 2013, Mr. Highhouse presented with abdominal pain to the Emergency Department

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of Saint Vincent Health Center. An abdominal ultrasound found that his gallbladder appeared to be full of stones; his common duct was normal. There was no definitive wall thickening or pericholecystic fluid. He was diagnosed as having cholelithiasis without obstruction causing right upper quadrant pain. He also had systolic hypertension. He was discharged, but advised to seek immediate medical attention if his abdominal pain increased.

Mr. Highhouse was admitted to Saint Vincent Health Center on May 9, 2013. Dr. Romero did coil embolization of the re-canalized basilar tip aneurysm on May 9, 2013 and placed additional coils. During the procedure, a 2 by 1 centimeter Delta coil was displaced and could not be retrieved. A permanent endovascular stenting device was placed in the right posterior cerebral artery. During this three day admission, Mr. Highhouse had bouts of nausea and vomiting unrelieved with Phenergan infusion; Dr. Romero ordered Zofran. Mr. Highhouse also experienced 10/10 back pain and was medicated with Dilaudid. On May 10, 2013 laboratory testing found anemia and leukocytosis. He was discharged on May 11, 2013.

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On May 14, 2013, Mr. Highhouse was seen in the Emergency Department of Saint Vincent Health Center due to recurrent abdominal pain. A repeat CT scan of his abdomen and pelvis found moderate right retroperitoneal hematoma mainly involving the psoas muscle with a tiny left adrenal nodule. He had a history of having undergone a cholecystectomy three weeks before and an aneurysm coiling five days before. He was diagnosed as having post-procedural changes associated in the right groin arteriotomy site with no significant hematoma or drainable fluid collection identified. Laboratory testing found an elevated bilirubin. He was admitted and his admission diagnoses included recent basilar artery coiling, history subarachnoid hemorrhage, hepatitis C, nephrolithiasis, atrial fibrillation, depression, chronic headaches, and hypertension.

A hospitalist note on May 15, 2013 documented that he had a retroperitoneal hematoma. There was concern about treating him with Plavix because of the risk of bleeding, but risk of cerebral vascular accident if not anticoagulated. Mr. Highhouse preferred taking the Plavix. Mr. Highhouse was discharged on May 18, 2013. His discharge diagnoses included a large right retroperitoneal hematoma, transaminitis, elevated bilirubin secondary to hematoma, and fever and

leukocytosis secondary to the hematoma.

On June 4, 2013, Mr. Highhouse saw Dr. Michael Orinick, III, psychiatrist, in follow-up at the VA Traumatic Brain Injury Clinic. Dr. Orinick reported that Mr. Highhouse was referred from the Polytrauma TBI Clinic. Mr. Highhouse was noted to have a history of a brain aneurysm in 2011 seen on MRI. A subarachnoid hemorrhage occurred on January 29, 2012 and was manifest by his inability to stand with nausea and vomiting. Treatment included coiling done by Dr. Romero and additional coiling a few months later. Dr. Orinick documented that Mr. Highhouse had passed out about a week prior to his previous visit. He had a history of previous presyncopal episodes associated with headaches. Testing showed that he had a recurrence of his previously treated aneurysm and underwent repeat coiling on May 9, 2013. He also underwent an emergency cholecystectomy in the Buffalo VA.

Dr. Orinick also documented that Mr. Highhouse reported continued episodes of lightheadedness relieved by sitting down. Since the most recent coiling procedure, Mr. Highhouse had worsened

memory difficulties and problems with visual focusing, especially in the mornings. Since his aneurysmal bleed, he had persistent headaches and neck pain with periodic severe, stabbing pain in his limbs lasting minutes at a time. The drenching night sweats had resolved with medication.

The diagnoses listed by Dr. Orinick included that Mr. Highhouse was status post aneurysmal bleed/subarachnoid hemorrhage with repeated coiling procedures and residual neurological problems. A cervical spine MRI had been obtained due to his bilateral positive Hoffman signs, neck pain, and periodic limb pains; the MRI did not show evidence of any spinal cord pathology. Optometry had evaluated him regarding his visual problems, but Mr. Highhouse was not interested in an Audiology evaluation of his hearing.

Dr. Orinick was still recommending speech therapy to evaluate his post-concussive residuals including memory and other cognitive issues; neuropsychological testing was being considered. Medication to improve his sleep was also being pondered. Dr. Orinick reiterated that Mr. Highhouse should always use a cane with ambulation to prevent falls. A Social Work

consultation was sent due to Mr. Highhouse's financial concerns. A follow-up visit was planned in four months.

Dr. Romero saw Mr. Highhouse for an office visit on June 19, 2013. Dr. Romero noted that the patient's coil treatment was complicated by a small displacement of the coil during the treatment into the left posterior cerebral artery system at a branch point. Attempts to extract the coil were unsuccessful. He had also been found to have a right retroperitoneal hematoma involving the psoas muscle, attributed to post-procedure bleeding. The bleed caused back pain and he developed anemia. Dr. Romero recommended continued use of Plavix and discussed at length with Mr. Highhouse the use of a walking device for stability due to lightheadedness.

On August 8, 2013, Mr. Highhouse was admitted to Saint Vincent Health Center. On August 8, 2013, diagnostic testing included an MR cerebral angiogram that redemonstrated a persistent partially canalized basilar tip aneurysm. There was also segmental stenosis of 6 millimeters of the basilar artery proximal to the aneurysm. Additionally, there was nonvisualization of the P1

segment on the left that had developed since the prior study possibly related to segmental occlusion. Mr. Highhouse was discharged from the hospital on August 11, 2013.

On August 15, 2013, Mr. Highhouse underwent a Social Security Bureau of Disability Determination evaluation. Glen Bailey, Ph.D. did a mental status evaluation and documented:

Axis I: Adjustment disorder with mixed emotional features

Cognitive disorder

Axis II: None

Axis III: Status post two aneurysms

Balance issues

Memory and concentration difficulties

High blood pressure

Vision and hearing problems

Cluster headaches

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Axis IV: Occupational problems, health issues

Axis V: Global assessment of functioning: 55

On September 4, 2013, Mr. Highhouse was seen by Jeffrey Esper, D.O. for an office visit regarding his history of cerebral aneurysm, dizziness, and visual changes. He reported occasionally slurred speech and intermittent vertigo, especially with looking upward. Mr. Highhouse denied diplopia or loss of vision. His balance was impaired and he had fallen once. There had been one episode of syncope prior to one of the aneurysm procedures. He denied focal numbness or weakness or a history of seizures. Examination found that there was hypesthesia to pinprick on his right side, but vibratory sensation and proprioception were intact. There was also hypesthesia on his right side to cold temperature. He had normal tone and muscle bulk on his upper and lower limbs and no fasciculations, contractures, or deformities. No abnormal movements or posturing were detected and there were no restrictions or functional limitations. His motor examination found normal strength with the major muscle groups of his upper and lower limbs bilaterally. Dr. Esper diagnosed basilar tip cerebral aneurysm with mild narrowing,

hallucinations, and daily headaches.

On September 5, 2013, Mr. Highhouse voiced frustrations to the behavioral health personnel at the VA including Dr. McKinstrey and Ms. Kathleen Kowalski regarding his cognitive and memory problems and his concern about his future due to his frail physiology. Mr. Highhouse could not find employment and he was struggling with his affairs due to his cognitive impairment. The behavioral health assessment confirmed cognitive difficulties and that he would benefit from ongoing mental health therapy to reduce his emotional distress.

On September 6, 2013, Mr. Highhouse was seen in the Emergency Department of UPMC Hamot Hospital. He presented after a syncopal episode while firefighting. He reportedly had a loss of consciousness for a couple of minutes, but did not strike his head. He was found to be overweight with a BMI of 25.7. Laboratory testing revealed hypokalemia and hyperglycemia. A brain CT scan showed no evidence of acute gross intracranial hemorrhage, mass effect, or calvarial fracture. There was mildly hyperdense appearance of the transverse sinuses, straight

sinus, and superior sagittal sinus which could have been due to dehydration. He was diagnosed as having a likely vasovagal episode. He was discharged to home.

On September 6, 2013, Mr. Highhouse's Citalopram dosage was increased to 40 milligrams to treat his depression. Behavioral progress notes on September 24, 2013 and October 21, 2013 indicated that Mr. Highhouse had an anxiety disorder, depressive disorder, and cognitive disorder. Mr. Highhouse stated that his mood was improved after the increase in the dosage of Citalopram. He continued to have impaired memory and decreased concentration since his surgeries.

Mr. Highhouse was seen by Dr. Romero on October 31, 2013 for an office visit. Dr. Romero noted that an MRA had been done in August and again demonstrated persistence of a partially canalized basilar tip aneurysm despite deployment of an endovascular reconstructive device. He continued to have memory difficulties that were present since 2012. Dr. Romero recommended further angiographic testing of the basilar tip aneurysm and continued Plavix.

PHYSICAL MEDICINE AND REHABILITATION EVALUATION

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Margaret B. Harrington, optometrist, did a visual evaluation on December 16, 2013 and found to evidence of retinopathy. On December 16, 2013, Charles Romero, M.D. did cerebral angiography. This test showed two intracranial aneurysms, one at the level of the basilar artery tip and a second at the anterior communicating artery level. Dr. Romero reported that there was evidence of re-canalization of the previously treated aneurysm arising from basilar artery tip with a small compartment arising from the neck on the left where the coils appeared loosely packed. The compartment measured approximately 6 X 4 millimeters and was localized at the aneurysm base on the left and incorporating the posterior wall. The previously treated aneurysm arising from the anterior communicating artery complex appeared well treated with no evidence of aneurysm growth, coil compaction, or re-canalization.

On January 21, 2014, Dr. Romero did an intracranial coil embolization of the basilar artery tip aneurysm re-canalization. The operative report further concluded that the basilar artery tip aneurysm compartment was successfully closed with an additional 5 detachable coils with occlusion of greater than 95% of the aneurysm dome remaining in the neck portion. On January

23, 2014, Mr. Highhouse was discharged to home with instructions on management of his groin site. He was to continue Plavix. He was limited to lifting 10 pounds or less. During his admission he received Citalopram, Hydrochlorothiazide, Verapamil, and Plavix.

On January 28, 2014, Dr. Russ documented that Mr. Highhouse had chronic mild memory and concentration loss without change. On April 2, 2014, Dr. Romero ordered an occipital nerve block at the VA for treatment of his headaches. In a visit with Dr. Romero on September 4, 2014, Mr. Highhouse was diagnosed as having attention and concentration deficits. Dr. Romero's note further indicated that Mr. Highhouse had complaints of worsening concentration and that he had issues with this since his subarachnoid hemorrhage. Dr. Romero also documented that Mr. Highhouse continued to have headaches, dizziness, lightheadedness, disturbances in coordination, confusion, loss of balance, disorientation, and memory loss.

On October 21, 2014, an MRI of his brain showed no acute infarct or hemorrhage, but some cerebral atrophy was detected. He was noted to have a history of anterior communicating artery

and basilar apex aneurysms with coil pack placements. An MR angiogram of his brain on October 29, 2014 showed no evidence of aneurysm re-canalization.

Mr. Highhouse reports that he underwent another cerebral angiogram in January 2015 in UPMC Hamot Hospital with no evidence of recanalization of either previously treated aneurysm. He was seen by Dr. Romero and no further surgery was recommended at that time. Mr. Highhouse is followed by Sheryl A. Russ, D.O., his primary care physician at the VA Hospital every three to four months; a follow-up visit is scheduled for tomorrow. Dr. Charles Romero, neurosurgeon, follows Mr. Highhouse every three to six months and as needed. Dr. Romero plans yearly assessments of Mr. Highhouse's cerebral circulation through angiography as surveillance. He is not being followed by any other physicians presently. No surgery is presently planned. He is not receiving any formal nursing or therapy care presently.

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CURRENT MEDICAL CONDITION:

Mr. Thede Highhouse has ongoing cognitive impairments due to the aneurysmal subarachnoid hemorrhages. His memory is especially affected. Mr. Highhouse reports that his only memory of the initial coiling procedure was Dr. Romero saying that "if he is not in the operating room in five minutes, he is going to die." He also has decreased attention and concentration. Mr. Highhouse reports that he "doesn't even try" to do mental math. He has frequent word finding difficulties. Intermittent dizziness most often occurs when he stands; therefore, he has to stand up slowly. He notes associated spinning of the room. At the time of the visit, Mr. Highhouse is not having visual symptoms like diplopia, blurred vision, or loss of vision. His balance is impaired and he recently fell on stairs.

Mr. Highhouse reports having intermittent needle-like pain in both of his hands extending to his forearms. This pain sometimes also involves both of his feet and lower limbs. This pain occurs several times per day, but is fleeting in duration. He denies experiencing this pain presently. During the last month this pain ranged up to a 3 to 4 on a scale of 0 to 10 with 10 being the most

severe pain of his life.

Paresthesias occur in both of his hands. He has diffuse weakness that he attributes to "being in bed for half a year." He fatigues easily. No increased warmth, redness, or swelling of any of his limb joints has been detected. There is pain in both of his elbows that he describes as "feeling like a bruise."

Mr. Highhouse denies having seizures. No swallowing difficulties have been noted. He denies having had pneumonia recently. Nausea each morning since his most recent surgery makes him unable to eat breakfast. He denies having urinary incontinence or retention. There is a delay in initiating his stream and it is decreased. Urinary urgency occurs often. He has not had a recent urinary tract infection. Neither constipation, nor diarrhea has occurred recently. He has occasional cramps, especially in his back. His hearing is decreased in both ears; testing was done after his subarachnoid hemorrhage, but has not been checked recently. He now wears trifocals. He had initial loss of the sense of smell after the subarachnoid hemorrhage, but he denies any loss

now. However, "food does not taste the same." Headaches occur two to three times per week and last all day at times. His headache pain is worse if he bends forward. The pain is in the frontal region. No skin breakdown has occurred recently, but he "reports having dry skin on his elbows and knees" bilaterally.

No flashbacks or nightmares have occurred recently. He reports that his most significantly personality change is that he is now "mellower and more laid back." He has intermittent depression and is anxious, especially about his finances and his pets. Mr. Highhouse also reports "getting excited easily and not liking being stressed."

Mr. Highhouse reports being independent with basic activities of daily living. However, these activities take much longer and are fatiguing. He has particular difficulty dressing due to his impaired balance. He can do basic home maintenance, but he does so slowly and has to take frequent breaks. Although he can drive, it is only for short distances.

Mr. Highhouse's typical day begins with his arising between 8:00 a.m. and 11:00 a.m. He never eats breakfast now, but has lunch around noon and supper between 4:00 p.m. and 5:00 p.m. He reports that he retires "when he is tired;" this varies between 8:00 p.m. and 2:00 a.m. Mr. Highhouse reports that he awakens every one to two hours at night; he attributes this to his taking "water pills." He notes that he often sleeps twelve hours per night and "could do it every day." He attributes his hypersomnolence to his medication regimen. He also reports napping for about two hours per day. His days are spent "cleaning up, doing laundry, and caring for his animals including seven cats, three ferrets, and ten fish."

PAST MEDICAL HISTORY:

Mr. Highhouse has a history of hypertension since his subarachnoid hemorrhage. He also developed atrial fibrillation after the subarachnoid hemorrhage. He denies a history of diabetes, myocardial infarction, tuberculosis, cancer, thyroid disease, peptic ulcer disease, or breathing

problems. He had Bell palsy on the left side of his face as a child around 5 or 6 years of age. He has a history of nephrolithiasis, but has not undergone surgery. He also has a history of hepatitis C, nephrolithiasis, and diverticulosis. He previously underwent a tonsillectomy around age 15, an appendectomy around age 25, a right shoulder rotator cuff surgery around 2005, and a cholecystectomy in 2014.

Prior to the subarachnoid hemorrhage, Mr. Highhouse was independent with activities of daily living, driving, home maintenance, and work. He had occasional back pain, but no chronic pain issues. He had never been treated for depression or an anxiety disorder.

CURRENT MEDICATIONS, DRUG ALLERGIES, & ADAPTIVE EQUIPMENT:

Mr. Highhouse presently takes Hydrochlorothiazide 12.5 milligrams daily, Citalopram 40 milligrams daily, Verapamil 240 milligrams daily, and Clopidogrel 75 milligrams daily. He has a

possible drug allergy to penicillin.

Adaptive equipment used by Mr. Highhouse includes shoes with cleats for use in the winter and a cane. He was given a notebook to use for a daily planner, but he admits "that he is not good at using it." He plans to have handles placed in his shower to improve his balance with bathing since he becomes dizzy when he tries to wash his hair.

REVIEW OF SYSTEMS:

Mr. Highhouse has continuous aching neck pain that radiates to his right shoulder. He rates this pain presently as a 1 to 2 with a thirty-day range of 1 to 6. He has intermittent lower back pain that preceded his subarachnoid hemorrhage, but is worse now. This pain is generally sharp and his back "locks up" at times. He denies having back pain presently, but during the last month, it ranged up to an 8. He denies having any recent, significant chest or abdominal pain. His current

weight is about the same as before the subarachnoid hemorrhage.

Mr. Highhouse has occasional palpitations, but denies recent shortness of breath, dyspnea on exertion, or hemoptysis. He does have epistaxis each morning. No hematemesis, hematochezia, or melena has been detected. He has a history of recurrent urinary tract calculi, but denies recent urinary tract infection or hematuria. There is no history of skin cancer.

SOCIAL HISTORY:

Mr. Thede Mohr Highhouse has been married four times; he is separated from his fourth wife. She left him most recently just before Christmas. He has five children, three sons and two daughters and six grandchildren. He lives alone in a one story-house with a basement. The house has not yet been modified to accommodate his impairments. He plans to change the shower and add railing to the steps at the entrance to the house.

Mr. Highhouse reports that his only current hobbies are watching television and taking care of his pets including seven cats, three ferrets, and ten fish. Prior to his aneurysmal bleeds, he enjoyed hunting and fishing often, but has engaged in these activities far less often since.

Mr. Highhouse's father lived until age 93, but died from diabetes. His mother died around age 84 of unknown cause.

VOCATIONAL HISTORY:

Mr. Highhouse quit school in the 12 grade, but later received a GED. He served in the navy for two years. He did not attend college, but is a certified welder and took multiple firefighting training courses. His previous employment was as a master carpenter; he was working part time when the aneurysm bled. Although he has tried, he has not been able to return to steady work in any capacity since he suffered the aneurysmal bleed.

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PHYSICAL EXAMINATION:

Mr. Thede Mohr Highhouse is a 59-year-old white male in no acute distress. He can ambulate independently, but seems mildly unsteady with turns. No pain behavior is detected. Examination of his head does not detect any evidence of external trauma and no scars are noted. No bruit is discerned on auscultation.

His neck examination does not detect any tenderness overlying his cervical spine or paracervical muscle regions. His carotid pulses are 2+ and symmetrical and no bruit is discerned on auscultation. His neck mobility includes normal flexion and extension, but lateral bending is limited to 15 degrees bilaterally and rotation is limited to 25 degrees on each side. No scars are noted. Examination of his back detected tenderness overlying his upper thoracic spine and paraspinal muscle regions bilaterally, especially around T 2-T 3. His back mobility included flexion to 75 degrees, lateral bending to 10 degrees bilaterally, and rotation to 20 degrees on each side.

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Cardiac examination finds normal heart sounds and no murmur is discerned. His lungs are clear to auscultation. Abdominal examination reveals normal bowel sounds and no tenderness or rebound is detected.

Neurological examination reveals that Mr. Highhouse is alert and oriented in all three spheres. Cranial nerve testing finds full extraocular movements, but he has one to two beats of nystagmus with right far lateral gaze. He has symmetrical light touch facial sensation and symmetrical facial movements. He can hear conversational level speech. His tongue protrudes in the midline. His balance is adequate with sitting and standing, but mildly impaired with ambulation. Vibratory sensation is mildly decreased on his upper limbs bilaterally; on his lower limbs, vibratory sensation is moderately decreased at his knees and severely decreased at both ankles. He can activate the major muscle groups of his upper and lower limbs bilaterally, but has diffuse weakness and incoordination. His muscle stretch reflexes are 2+ and symmetrical on his upper and lower limbs bilaterally; no clonus is detected. Babinski testing bilaterally obtains no response. His Hoffman reflex is positive on the left, but negative on the right. Palmomental

testing is negative bilaterally. Romberg testing finds some pronator drift and instability bilaterally. He also displays past pointing with finger to nose testing bilaterally with his eyes closed.

Examination of his shoulders, elbows, and wrists bilaterally does not detect any calor, erythema, or effusion. Further examination of these joints finds normal passive range of motion in all planes. Additional examination of his upper limbs reveals that his brachial and radial pulses are 2+ and symmetrical.

Examination of his hips, knees, and ankles bilaterally does not detect any calor, erythema, or effusion. Further examination of his hips joints finds that internal rotation is limited to neutral bilaterally. He has normal passive range of motion of his knees on both sides. Dorsiflexion of his ankles is limited to neutral when his knees are extended, but is normal when his knees are flexed. Further examination of his lower limbs reveals that his pedal pulses are 2+ and symmetrical and no pedal edema is detected.

MEDICAL IMPRESSIONS THAT ARE DIRECT CONSEQUENCES OF THE BASILAR TIP ANEURYSM RUPTURE:

1. Status post ruptured basilar artery tip aneurysm.
2. Status post subarachnoid hemorrhage.
3. Status post coil embolization of basilar artery tip aneurysm.
4. Status post cerebral salt-wasting syndrome with hyponatremia.
5. History, hypertension.
6. Status post atrial fibrillation/flutter.
7. Probable neurogenic bladder with delayed initiation, impaired flow, and urgency.
8. Status post embolization of anterior communicating artery aneurysm.
9. Status post recurrent urinary tract infections.
10. Status post re-canalization of basilar tip aneurysm.
11. Status post repeated coil embolization of re-canalized basilar tip aneurysm.
12. Basilar artery segmental stenosis.
13. Cerebral atrophy.

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14. Status post right retroperitoneal hemorrhage.
15. Impaired cognition including decreased attention, concentration, memory, and problem solving.
16. Expressive aphasia with marked word finding difficulties.
17. History, headaches with photophobia and phonophobia.
18. Bilateral impaired hearing, worsened since subarachnoid hemorrhage.
19. Sleep disorder.
20. Visual impairments.
21. History, dizziness, lightheadedness, and vertigo.
22. Impaired balance.
23. History, morning nausea.
24. Bilateral upper greater than lower limb paresthesias and dysesthesias.
25. Impaired sense of taste.
26. History, chronic fatigue.
27. History, anxiety disorder.
28. History depression.

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CASE ANALYSIS & RECOMMENDATIONS:

Mr. Thede Mohr Highhouse is status post ruptured basilar tip aneurysm that directly and proximately caused a subarachnoid hemorrhage. More immediately the subarachnoid hemorrhage caused nausea, gastrointestinal upset, vomiting, cerebral salt wasting syndrome, atrial fibrillation, massive thunderclap headaches, burning in his eyes, and speech disturbance. The subarachnoid hemorrhage caused a traumatic and permanent brain injury including a thalamic brain injury. The brain injury has caused Mr. Highhouse to have altered memory and sensation, decreased attention, concentration, and ability to perform mental math. The brain injury also caused word finding difficulties, intermittent dizziness, lightheadedness, vertigo, impaired balance, altered coordination, bilateral intermittent needle-like hand pain and paresthesias, diffuse weakness, chronic fatigue, urinary symptoms, reduced hearing, impaired sense of taste, an anxiety disorder, cognitive disorder, depression, and headaches. The headaches often have associated syncope, gastrointestinal upset, nausea, vomiting, and visual disturbances. His sleep is also affected and he seems to have hypersomnia, nightmares, and emotional distress. Due to his ongoing symptoms, Mr. Highhouse becomes fatigued with performing basic activities

of daily living. He has not been able to return to work in any capacity.

Due to the complexity of his injuries and the multiple ongoing medical issues, Mr. Highhouse should be followed two to four times per year and as needed by a primary care physician for evaluation and management of the sequelae of his brain injury. This physician should obtain needed diagnostic testing as the patient's medical condition warrants. He would benefit presently from neuropsychological testing and an evaluation by a speech pathologist to delineate the full extent and nature of his ongoing cognitive and linguistic deficits and to help direct an ongoing rehabilitation effort. Laboratory testing including a complete blood cell count (CBC) and complete metabolic profile should be done twice per year and as needed. A sleep study should be done to determine the nature and extent of his sleep disorder. This physician should also make referrals to other health care providers as the patient's condition warrants.

Due to his urological symptoms and likely neurogenic bladder, Mr. Highhouse should be followed once to twice per year by a urologist. He will need associated diagnostic testing

including twice yearly BUN, creatinine, creatinine clearance, urinalysis, and urine culture. Renal and bladder ultrasound should be done annually and cystoscopy every two to three years. Mr. Highhouse should be followed annually by a neuro-ophthalmologist to monitor and manage his visual symptoms and impairments. He should be seen annually by a neuro-otolaryngologist regarding his hearing loss, dizziness, lightheadedness, and vertigo. A neurologist should monitor annually and as needed Mr. Highhouse's neurological functioning and check for potential complications including aneurysmal re-canalization, subarachnoid hemorrhage, and hydrocephalus. Associated diagnostic testing should include an annual and as needed brain CT scan, MRI, and/or MRA.

Mr. Highhouse should be followed every three months by a psychiatrist for prescription of psychotropic medications to treat his mood and anxiety disorder. He should also be seen weekly by a psychologist for six months to help him deal with his impairments and chronic pain. A physician pain management specialist should direct a more comprehensive approach to his multiple chronic pain problems. Treatment should include oral medications, injections, physical

modalities, and relaxation training. He should be followed by this pain management specialist every three months and as needed for prescription of his pain medications.

Mr. Highhouse should also be followed twice per year by a physician specializing in Physical Medicine and Rehabilitation to direct and prescribe an ongoing rehabilitation effort. Over his lifetime, he will need at least four to six additional courses each of physical, occupational, and therapies to deal with his pain, cognitive, and linguistic issues. Each of these courses of therapy is expected to average two to three sessions per week for two to three months. He will continue to need adaptive equipment including ambulatory aides like a cane and shoes with cleats. He should also use a daily planner and a shower chair. He will continue to need medications to deal with his chronic pain issues and psychological problems.

Due to his chronic fatigue, pain issues, cognitive and linguistic impairments, Mr. Highhouse should presently have the assistance of a certified nursing assistant or attendant two to four hours per day. He also needs assistance with basic home maintenance including lawn care and snow

removal. As he ages due to the impact of the aging process on his symptoms and impairments, Mr. Highhouse will likely need additional assistance with daily activities. By age 70, it is anticipated that he will need the help of an attendant or certified nursing assistant four to eight hours per day.

Despite the functional impairments and symptoms associated with his ongoing medical problems, Mr. Highhouse does not have a resultant reduced life expectancy associated with his brain injury. If he gets the care that he needs as outlined above, his life expectancy is normal.

All of the medical opinions expressed in this report are held within a reasonable degree of medical certainty and probability.

Richard Paul Bonfiglio, M.D.

Physician Specialist in Physical Medicine & Rehabilitation